14. Medicare Part B revenues;

    A. Total revenues received from Part B charges through Medicare intermediaries will be offset;

    B. Seventy-five percent (75%) of the total revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;

16. Activity income; and

17. Revenue recorded for donated services and commodities.

(B) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

(D) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(E) As applicable, restricted and unrestricted funds will be offset in each cost component, excluding capital, in an amount equal to the cost component's proportionate share of allowable expense.

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12) month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the Division. The cost report shall be submitted on forms provided by the Division for that purpose. Any substitute or computer generated cost report must have prior approval by the Division.

3. All cost reports shall be completed in accordance with the requirements of this plan and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this plan.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

6. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this plan, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the Department may terminate the provider's Medicaid participation agreement and if terminated retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the Division. Material which must be submitted or available upon request includes the following, but may include other documents to assist the Division's understanding of the submitted cost report.

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the Division, the Department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the Division, the Department or its agents;

G. Leases and/or rental agreements related to the activities of the provider if requested by the

Division, the Department or its agents;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the Division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the Division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the Division accept amended cost reports for rate determination or rate adjustment after the date of the Division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____
Signature Title Date

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this plan, including reasonable requests by the Division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the Division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the State of Missouri. Copies of documentation and records shall be submitted to the Division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven(7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the Division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the State of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the Division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the Division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering at a minimum the first two (2) full twelve (12) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and Generally Accepted Auditing Standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings and Statement of Cash Flow. For example, a provider begins participation in the Medicaid Program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12) month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Change in Provider Status.

1. If a provider notifies, in writing, the Director of the Institutional Reimbursement Unit of the Division prior to the change of control, ownership or termination of participation in the Medicaid Program, the Division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership or termination. Upon receipt of a cost report prepared in accordance with this plan, any payment that was withheld will be released to the selling provider.

2. If the Director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, $30,000 of the next available full month Medicaid payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than $30,000, the entire payment will be withheld. Once the cost report, prepared in accordance with this plan, is received the payment will be released to the provider identified in the current Medicaid participation agreement.

3. The Division of Medical Services may, at its discretion, delay the withholding of funds specified in paragraphs (10)(E)1. and 2. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the buying and selling provider may provide adequate assurances. The buying provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold thirty thousand dollars ($30,000) if the cost report is not timely filed.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the nursing facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity or entities that own, control or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year to year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this plan, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this plan.

*Substitute per letter dated 10/27/95 *

(11) Cost Components and Per Diem Calculation. The Division will use a cost report which has an ending date in calendar year 1992 which is on file with the Division as of December 31, 1993. No amended cost report will be accepted after December 31, 1993. If a facility has more than one cost report with periods ending in calendar year 1992, the cost report covering a full twelve (12) month period ending in calendar year 1992 will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in calendar year 1992 will be used.

(A) Patient Care. Each nursing facility's patient care per diem shall be the lower of:

1. Allowable cost per patient day for patient care as determined by the Division from the 1992 cost report trended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%; or

2. The per diem ceiling of 120% of the patient care median determined by the Division from the databank.

(B) Ancillary. Each nursing facility's ancillary per diem will be the lower of:

1. Allowable cost per patient day for ancillary as determined by the Division from the 1992 cost report, trended by the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4% and nine months of 1995 of 3.3%, for a total of 10.6%; or

2. The per diem ceiling of 120% of the ancillary median determined by the Division from the databank.